Utah Labor Commission
Industrial Accidents Division

2015
MEDICAL FEE STANDARDS

Effective December 1, 2014

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General Statement – Medical Care Reimbursement

The Utah Labor Commission annually sets the medical fee standards and updates, as needed, administrative rules for medical providers as defined and authorized in §34-2-407, Utah Code Annotated. The Commission adopted its first Relative Value Fee Schedule (RVS) in 1956 and has updated and maintained a Medical Fee Schedule until this present time through the efforts of many individuals serving on the Commission's Medical Advisory Committee.

The Utah Labor Commission with the approval of the Workers' Compensation Advisory Council has adopted the 2015 Medical Fee Standard. This standard is based on the 2014 Centers for Medicare and Medicaid Services (CMS) First Quarter 2014, Resource Based Relative Value Scale (RBRVS), and the 2014 American Medical Association (AMA) Current Procedural Terminology (CPT).

If a discrepancy occurs between the 2006 Impairment Guides and the AMA Fifth Edition Impairment Guides, Utah Workers' Compensation statute §34A-2-412 the permanent partial statutory benefits take precedent.

RBRVS – Definition of Use

The Centers for Medicare and Medicaid Services (CMS) published in the 2014 First Quarter Essential RBRVS has been selected as the method for calculating reimbursement using the 2014 AMA CPT coded procedures for those providing care for injured workers covered under the Utah Workers' Compensation Act. A copy of the current AMA CPT may be obtained by calling 1-800-621-8335. A copy of the 2014 First Quarter Resource Based Relative Value Scale (RBRVS) – 1st Quarter Emergency Update designated as 1761, can be obtained by calling Optum at 1-800-464-3649.

To determine the total amount for reimbursement, the RVU assigned to each CPT code is to be multiplied by each specialty's unique 2014 Utah Labor Commission's conversion factor to obtain the total reimbursement value.

[Example: 2014 CPT's RVU) 1761 Edition x 2014 Utah Labor Commission's designated conversation factor as per specialty expressed in dollars = the Total Reimbursement Value.]

It is highly recommended that providers and payers purchase the 2014 First Quarter Edition of Optum's RBRVS, 1761/RBRCU/U1775R—RBRC14/RBRC/U1775R Edition. This is a comprehensive listing of all RVUs.

+ Setting for Procedure: The physician must identify the setting where the procedure was performed when billing - Facility or Non Facility

R612-300-1. Purpose, Scope and Definitions.

A. **Purpose and scope. Pursuant to authority granted the Utah Labor Commission under §34A-2-407 (9) and § 34A-2-407.5 (1) of the Utah Workers' Compensation Act, these rules establish:**

1. Reasonable fees for medical care necessary to treat workplace injuries;
2. Standards for disclosure of medical records;
3. Reporting requirements; and
4. Treatment protocols and quality care guidelines.

B. **Definitions.** The following definitions apply within Rule 612-300:

1. " Health care provider" is defined by § 34A-2-111 (1) (a) as "a person who furnishes treatment or care to persons who have suffered bodily injury" and includes hospitals, clinics, emergency care centers, physicians, nurses and nurse practitioners, physician's assistants, paramedics and emergency medical technicians.
2. "Injured worker" is an individual claiming workers' compensation medical benefits for a work-related injury or disease.
3. "Payor" is the entity responsible for payment of an injured worker's medical expenses;
4. "Physician" is defined by § 34A-2-111 (1) (b) to included any licensed podiatrist, physical therapist, physician, osteopath, dentist or dental hygienist, physician's assistant, naturopath, acupuncturist, chiropractor, or advance practice registered nurse.
3. "Workplace injury" is an injury or disease compensable under either the Utah Workers' Compensation Act or the Utah Occupational Disease Act.

R612-300-2. Obtaining Medical Care for Injured Workers.

A. **Right of payor to designate initial health care provider.**

1**.** A Payor may adopt managed health care programs. Such programs may designate specific health care providers as "preferred providers" for providing initial medical care for injured workers.

2. A preferred provider program must allow an injured worker to select from two or more health care providers to obtain necessary medical care. At the time a preferred provider program is established, the payor must notify employees of the requirements of the program.

3. If the requirements of subsection A. 2 are met, an injured worker subject to a preferred provider program must seek initial medical care from a preferred provider unless:

   a. No preferred provider is available;

   b. The injured worker believes in good faith that his or her medical condition is not a workplace injury; or

   c. Travel to a preferred provider is unduly burdensome.

4. If an injured worker who is subject to a preferred provider program fails to obtain initial medical care from a preferred provider, the payor's liability for the cost of such initial medical care is limited to the amount the payor would have paid a preferred provider. The injured worker may be held personally liable for the remaining balance.

B. **Liability for medical expense incurred at payor's direction.** If a payor directs an injured worker to obtain an initial medical assessment of a possible work injury, the payor is liable for the cost of such assessment.

1. A medical provider performing an initial assessment must obtain the payor's preauthorization for any diagnostic studies beyond plain x-rays.

C. **Injured worker's right to select provider after initial medical care.** After an injured worker has received initial care from a preferred provider, the injured worker may obtain

subsequent medical care from a qualified provider of his or her choice. The payor is liable for the expense of such medical care.

1. An injured worker's right to select medical providers is subject to subsection D. of this rule, "Limitations to Injured Worker's Right to Change Physicians."

D. **Limitations on injured worker's right to change physicians.**

1. An injured worker may change health care providers one time without obtaining permission from the payor. The following circumstances **do not** constitute a change of health care provider:

a. A treating physician's referral of the injured worker to another health care provider for treatment or consultation;

b. Transfer of treatment from an emergency room to a private physician, unless the emergency room was designated as the payor's preferred provider;

c. Medically necessary emergency treatment;

d. A change of physician necessitated by a treating physician's failure or refusal to rate a permanent partial impairment.

2. The injured worker shall promptly report any change of provider to the payor.

3. After an injured worker has exercised his or her one-time right to change health care providers, the worker must request payor approval of any subsequent change of provider. If the payor denies or fails to respond to the request, the injured worker may request approval from the Director of the Division of Industrial Accidents. The Director will authorize a change of provider if necessary for the adequate medical treatment of the injured worker or for other reasonable cause.

4. An injured worker who changes health care providers without payor or Division approval may be held personally liable for the non-approved provider's fees.

E. **Hospital or surgery pre-authorization.** Except when immediate surgery or hospitalization is medically necessary on an emergency basis, surgery or hospitalization must be pre-authorized by the payor.

1. Within two working days of receipt of a request for authorization, the payor shall notify the physician and injured worker that the request is either approved or denied, or is undergoing medical review.

2. Any medical review of a pending request for authorization must be conducted promptly.

F. **Notification required from injured workers leaving Utah.** Section 34A-2-604 of the Workers' Compensation Act requires injured workers receiving medical care for a workplace injury to notify the Industrial Accidents Division before leaving the state or locality. Division Forms 043 and Form 044 are to be used to provide such notice.

G. **Injured worker's right to privacy.** No agent of the payor may be present during an injured worker's medical care without the consent of the injured worker. However, if the payor's agent is excluded from a medical visit, the physician and the injured worker shall meet with the agent at the conclusion of the visit or at some other reasonable time so as to communicate regarding medical care and return-to-work issues.

H. **Payor's right of medical examination.** The payor may arrange for the medical examination of an injured worker at any reasonable time and place. A copy of the medical examination report shall be made available to the Commission upon request.

R612-300-3. Required Reports.

A. **Form 123, Physician's Initial Report.** Within one week after providing initial medical

care to an injured worker, a health care provider shall complete "Form 123 - Physicians' Initial Report." The provider shall fully complete Form 123 according to its instructions. The provider shall then file Form 123 with the Division and payor.

1. Form 123 must be completed and filed for every initial visit for which a bill is generated, including first aid, when the worker reports that his or her medical condition is work related.

2. If initial medical care is provided by any health care provider other than a physician, Form 123 must be countersigned by the supervising physician.

B. **Form 221, Restorative Services Authorization.** Form 221, "Restorative Services Authorization Form" required by Rule 612-300-5. C. 7. shall be filed with both the payor and the Division.

C. **Forms 043, Employee's Intent to Leave State, and Form 044, Attending Physician's Statement.** These forms are to be submitted to the Division before an injured worker leaves Utah.

D. **"Form 110 - Release to Return to Work."** Form 110 shall be mailed by either the health care provider or payor to the injured worker and Division within five calendar days after the health care provider releases the injured worker to return to work.

R612-300-4. General Method For Computing Medical Fees.

A. **Adoption of "CPT" and "RBRVS."** The Labor Commission hereby adopts and by this reference incorporates:

1. "Optum 2014 Current Procedural Coding Expert, for CPT codes descriptors only with Medicare essentials enhanced for accuracy," ("CPT" hereafter); and

2. "Optum 2014 The Essential RBRVS, 2014 for the established RVU 1st Quarter Emergency Update," designated as 1761/RBRCU/U1775R—RBRC14/RBRC/U1775R, ("RBRVS" hereafter).

B. **Medical fees calculated according to CPT and RBRVS.** Unless some other provision of these rules specifies a different method, the 2014 CPT code descriptors and the 2014 RBRVS values are to be used in conjunction with the "conversion factors" established in subsection C. of this rule to calculate payments for medical care provided to injured workers.

C. **Conversion factors.** Fees for medical care of injured workers shall be computed by determining the relative value unit ("RVU") assigned by the RBRVS to a CPT code and then multiplying that RVU by the following conversion factors for specific medical specialties:

1)	Anesthesiology (1 unit per 15 minutes of anesthesia)	$53.00;
2)	Medicine (Evaluation and Medicine Codes 99201- 99204 and 99211-99214)	$50.00;
3)	Pathology and Laboratory	$56.00;
4)	Radiology	$58.00;
5)	Restorative Services	$50.00;
6)	Surgery (all 20000 codes, codes 49505 thru 49525, and all 60000 codes)	$62.00;
7)	Other Surgery	$40.00.

D. **Fees for medical care not addressed by CPT/RBRVS, or requiring unusual treatment.**

1. The payor and medical provider may establish and agree to a reasonable fee for medical care of an injured worker if:

a. neither the CPT/RBRVS or any other provision of these rules address the medical care in question; or

b. application of CPT/RBRVS or other provisions of these rules would result in an inadequate fee due to extraordinary difficulty of treatment.

2. If the medical provider and payor cannot agree to a reasonable fee in such cases, the provider can request a hearing before the Commission's Adjudication Division to establish a reasonable fee.

R612-300-5. Fees for Specific Procedures.

A. **Needle Procedures:** Trigger point injections are reported per muscle. Payment under CPT code 20553 for injections of up to three muscles is the maximum allowed for any one treatment session, regardless of the number of muscles treated.

B. **Radiology.**

1. The cost of radioisotopes, gadolinium and comparable materials may be charged at the provider's cost plus 15%.

2. When x-rays are reviewed as part of an independent evaluation of the patient, a consultation, or other office visit, the review is included as a part of the basic service to the patient and may not be billed separately.

C. **Restorative Services.**

1. The following criteria must be met before payment is allowed for restorative services:
   a. The patient's condition must have the potential for restoration of function;
   b. The treatment must be prescribed by the treating physician;
   c. The treatment must be specifically targeted to the patient's condition; and
   d. The provider must be in constant attendance during the providing of treatment.

2. No payment is allowed for CPT codes 97024, diathermy; 97026, infrared therapy; 97028, ultraviolet therapy/cold laser therapy; 97005, athletic training evaluations; 97006, athletic training reevaluation.

3. All restorative services provided must be itemized even if not billed.

4. Medical providers billing under CPT codes 97001 through 97703 are limited to payment for a maximum of three procedures/units per visit, or six procedures if different sites are treated. Services billed under CPT codes 97545, 97546 and 97150 require preauthorization and are limited to 4 units per injury. The payor shall pay the three highest valued procedures for each treatment site for the visit.

5. Patient education is to be billed using CPT code 97535 rather than codes 98960 through 98962, and is limited to 4 units per injury claim.

6. The entire spine is considered to be a single body part or unit. For that reason, CPT codes 98941 through 98943 and 98926 through 98929 may not be used for billing purposes;

7. For physical therapy and occupational therapy:
   a. Physicians and physical therapists may bill for up to 2 modalities/procedures per day;
   b. With prior authorization from the payor, physicians and physical therapists may make additional billing when justified by special circumstances.

8. Any medical provider billing for restorative services shall file the appropriate version of Form 221, "Restorative Services Authorization (RSA) form" with the payor and the Division within ten days of the initial evaluation. Subjective/objective/assessment/plan ("SOAP") notes are to be sent to the payor in addition to the RSA form. SOAP notes are not to be sent to the Division unless requested.
   a. Upon receipt of the provider's RSA form and SOAP notes, the payor shall respond within ten days by authorizing a specified number of treatments or denying the request. No more than eight treatments may be provided during this ten-day authorization period.

b. A payor may deny the requested treatments for the following reasons:

i) The injury or disease being treated is not work related; or

ii) The payor has received written medical opinion or other medical information indicating the treatment is not necessary. A copy of such written opinion or information must be provided to the injured worker, the medical provider, and the Division.

c. In cases where approval is received for initial treatment, the provider shall submit updated RSA forms and SOAP notes to the payor for approval or denial at least every six treatments.

d. An injured worker or provider may request a hearing before the Division of Adjudication to resolve issues of compensability, necessity of treatment, and compliance with this subsection's time limits.

D. **Functional Capacity Evaluations.** The following functional capacity evaluations require payor preauthorization and are billed in 15 minute increments under CPT code 97750:

1. A limited functional capacity evaluation to determine an injured worker's dynamic maximal repetitive lifting, walking, standing and sitting tolerance. Billing for this type of evaluation is limited to a maximum of 45 minutes.

2. A full functional capacity evaluation to determine an injured worker's maximum and repetitive lifting, walking, standing, sitting, range of motion, predicted maximal oxygen uptake, as well as ability to stoop, bend, crawl or perform work in an overhead or bent position. In addition, this evaluation includes reliability and validity measures concerning the individual's performance. Billing for this type of evaluation is limited to a maximum of 2.5 hours.

3. A work capacity evaluation to determine an injured worker's capabilities based on the physical aspects of a specific job description. Billing for this type of evaluation is limited to a maximum of 2 hours.

4. A job analysis to determine the physical aspects of a particular job. Billing is not subject to a maximum time limit due to the variability of factors involved in the analysis.

E. **Impairment Ratings and Insurance Medical Examinations.**

1. Impairment Rating by Treating Physician. Treating physicians shall bill for preparation of impairment ratings under CPT code 99455, with 2.0 RVU assigned/30 minutes.

2. Impairment Rating by Non-Treating Physician. Non-treating physicians may bill for preparation of impairment ratings under CPT code 99456, with 2.65 RVU assigned/30 minutes.

3. Medical Evaluations Commissioned by Payors. The Labor Commission does not regulate fees for medical evaluations requested by payors.

F. **Transcutaneous Electrical Nerve Simulators (TENS).** No fee is allowed for TENS unless it is prescribed by a physician and supported by prior diagnostic testing showing the efficacy of TENS in control of the patient's chronic pain. TENS testing and training is limited to four (4) sessions and a 30-day trial period but may be extended with written documentation of medical necessity.

G. **Electrophysiologic Testing.** A physician who is legally authorized by his or her medical practice act to diagnose injury or disease is entitled to the full fee for electrophysiologic testing. Physical therapists and physicians who are qualified to perform such testing but who are not legally authorized to diagnose injury or disease are entitled to payment of 75% of the full fee.

H. **Dental Injuries.**

1. Initial Treatment.

a. If an employer maintains a medical staff or designates a company doctor, an employee requiring treatment for a workplace dental injury shall report to such medical staff or doctor and follow their directions for obtaining the necessary dental treatment.

b. If an employer does not maintain a medical staff or designate a company doctor, or if such medical staff or doctor is unavailable, the injured worker may obtain the necessary dental care from a dentist of his or her choice. The payor shall pay the dentist at 70% of UCR for services rendered.

2. Subsequent treatment.

a. If additional dental care is necessary, the dentist who provided initial treatment may submit to the payor a request for authorization to continue treatment. The transmission date of the request must be verifiable. The request itself must include a description of the injury, the additional treatment required, and the fee to be charged for the additional treatment.

i. The payor shall respond to the request for authorization within 10 working days of the request's transmission. This 10-day period can be extended with written approval of the Director of the Industrial Accidents Division.

ii. If the payor does not respond to the dentist's request for authorization within 10 working days, the dentist may proceed with treatment and the payor shall pay the cost of treatment as contained in the request for authorization.

iii. If the payor approves the proposed treatment, the payor shall send written authorization to the dentist and injured worker. This authorization shall include the amount the payor agrees to pay for the treatment. If the dentist accepts the payor's payment offer, the dentist may proceed to provide the approved services and shall be paid the agreed upon amount.

iv. If the dentist proceeds with treatment without authorization, the dentist's fee is limited to 70% of UCR .

b. If the dentist who provided initial treatment is unwilling to provide subsequent treatment under the terms outlined in subsection 2.a., above, the payor shall within 20 calendar days direct the injured worker to a dentist located within a reasonable travel distance who will accept the payor's payment offer.

i. If, after receiving notice that the payor has arranged for the services of a dentist, the injured worker chooses to obtain treatment from a different dentist, the payor shall only be liable for payment at 70% of UCR. The treating dentist may bill the injured worker for the difference between the dentist's charges and the amount paid by the insurer.

c. If the payor is unable to locate another dentist to provide the necessary services, the payor shall attempt to negotiate a satisfactory reimbursement with the dentist who provided initial treatment.

I. **Drug Testing.** Drug screenings for addictive classes of pain medications shall be performed as recommended in the Utah Clinical Guidelines on Prescribing opiates for Treatment of Pain, Utah Department of Health 2009. The collection and billing shall be limited to one 80100 code per date of service, except for unusual circumstances.

J. **Procedures for Which No Fee is Allowed.** Due to a lack of evidence of medical efficacy, no payment is authorized for the following:

1. Muscle Testing, CPT codes 95832 through 95857;
2. Computer based Motion Analysis, CPT codes 96000 through 96004;
3. Athletic Training Evaluation, CPT codes 97005 and 97006;
4. Acupuncture, CPT codes 97810 through 97814;
5. Analysis of Data, now BR, CPT code 99090;
6. Patient Education, CPT codes 98960 through 98962;
7. Educational supplies, CPT code 99071; or
8. Thermograms, artificial discs, percutaneous diskectomies, endoscopic diskectomies,

IDEPT, platelet rich plasma injections, thermo-rhizotomies and other heat or chemical treatments for discs.

R612-300-6. Limitations on Fees of Specific Medical Providers and Non-Physicians.

A. **Physician assistants, nurse practitioners, medical social workers, nurse anesthetists, and physical therapy assistants.** Fees for services performed by physician assistants, nurse practitioners, medical social workers, nurse anesthetists, and physical therapy assistants are set at 75% of the amount that would otherwise be allowed by these rules and shall be billed using an 83 modifier.

B. **Assistant surgeons.** Fees for assistant surgeons are limited as follows:

1. Medical doctors, osteopaths and podiatrists, designated with an -80 modifier, are to be paid 20% of the primary surgeon's fee;

2. Minimum paramedicals, designated with an -81 modifier, are to be paid 15% of the primary surgeon's value or 75% of the amount allowed under subsection B. 1), above.

3. When a qualified resident surgeon is not available, 20% of the primary surgeon's fee;

4. Other paramedical assistants, such as surgical assistants, are not billed separately.

C. **Home health care.** The following fees, which include mileage and travel time, are payable for Home Health Codes 99500 through 99602:

1)	RN	$100/2hr.
2)	LPN	$75/2hr.
3)	Home Health Aide	$25/hr. + $6 additional 30 min.
4)	Speech Therapists	$80/visit
5)	Physical Therapy	$125/hr.
6)	Occupational Therapy	$125/hr.

7) Home Infusion Providers are to be paid according to contract between the payor and home infusion provider. If no contract is established, the payor shall pay the amount specified in Days Guidelines and pay UCR or Cost + 15% for the drugs and supplies.

D. **Acupuncturists, naturopathic providers and massage therapy.** Payor preauthorization is required for any services provided by acupuncturists and naturopaths. Payment for massage therapy is only allowed when administered by a medical provider and billed according to the requirements of Rule R612-300. 5. C, "Restorative Services."

E. **Ambulance.** Ambulance charges are limited to the rates set by the State Emergency Medical Service Commission.

R612-300-7. Billing and Payment.

A. **Billing limitations.**

1. Except as otherwise provided by a specific provision of the Workers' Compensation Act or these rules, an injured worker may not be billed for the cost of medical care necessary to treat his or her workplace injuries.

2. A health care provider may not submit a bill for medical care of an injured worker to both the employer and the insurance carrier.

B. **Discounting and down-coding.**

1. Discounting or reducing the fees established by these rules is permitted only pursuant to a specific contract between the medical provider and payor.

2. A payor may change the CPT code submitted by a health care provider under the following circumstances:

a. The submitted code is incorrect;

b. Another code more closely identifies the medical care;

c. The medical provider has not submitted the documentation necessary to support the code; or

d. The medical care is part of a larger procedure and included in the fee for that procedure.

3. If a payor changes a code number, the payor shall explain the reason for the change and provide the name and phone number of the payor's claims processor to the medical provider in order to allow further discussion.

C. **Place of treatment.** A medical provider's billing for a medical procedure must identify the setting where a procedure was performed.

1. In an office or clinic: Fees for procedures performed in an office or clinic are to be computed using the Non-Facility Total RVU.

2. In a facility setting: Fees for physician services for procedures performed in a facility are to be computed using the "Facility Total RVU," as the facility will be billing for the direct and indirect costs related to the service.

D. **Separate bills.** Separate bills must be presented by each medical provider within 30 days of treatment on a HCFA 1500 billing form. All bills must contain the federal ID number of the provider submitting the bill.

E. **Hospital fees.**

1. The Labor Commission does not have authority to set fees for hospital care of injured workers. However, hospitals are subject to the Commission's reporting requirements, and fees charged by health care providers for services performed in a hospital are subject to the Commission's fee rules.

2. Fees covering hospital care shall be separate from those for professional services and shall not extend beyond the actual necessary hospital care.

3. All billings must be submitted on a UB92 form, properly itemized and coded, and shall include all documentation, including discharge summary, necessary to support the billing. No separate fee may be charged for billing or documentation of hospital services.

F. **Charges for supplies, materials, or drugs.**

1. Ordinary supplies, materials or drugs used in treatment shall not be charged separately but shall be included in the amount allowed for the underlying medical care.

2. Special or unusual supplies, materials, or drugs not included as a normal and usual part of the service or procedure may be billed at cost plus 15% restocking fees and any taxes paid.

G. **Miscellaneous.**

1. A physician may bill the new patient E&M code when seeing an established patient for a new work injury.

2. Payment for hospital care is limited to the bed rate for semi-private room unless a private room is medically necessary.

3. Non-facility rvs total unit values apply, except that procedures provided in a facility setting shall be reimbursed at the facility total unit value and the facility may bill a separate facility charge.

4. Items that are a portion of an overall procedure are <u>not</u> to be itemized or billed separately.

5. Payors may round charges to the nearest dollar. If this is done on some charges, it must be done with all charges.

H. **Prompt payment and interest.**

1. All bills for medical care of injured workers must be paid within 45 days of submission to the payor unless the bill or some portion of the bill is in dispute. Any portion of the bill not in

dispute remains payable within 45 days of billing.
2. As required by Section 34A-2-420 of the Utah Workers' Compensation Act, any award for medical care made by the Commission shall include interest at 8% per annum from the date of billing for such the medical care.
I. **Billing disputes.** Payors and health care providers shall use the following procedures to resolve billing disputes.
1. The provider shall submit a bill for services with supporting documentation to the payor within one year of the date of service;
2. The payor shall evaluate the bill and pay the appropriate fee as established by these rules.
3. If the provider believes the payor has improperly computed the fee, the provider may submit a written request for reevaluation to the payor. The request shall describe the specific areas of disagreement and include all appropriate documentation. Any such request for re-evaluation must be submitted to the payor within one year of the date of the original payment.
4. Within 30 days of receipt of the request for re-evaluation, the payor shall either pay the additional fee due the provider or respond with a specific written explanation of the basis for its denial of additional fees. The payor shall maintain proof of transmittal of its response.
5. A payor seeking reimbursement from a provider for overpayment of a bill shall, within one year of the overpayment, submit to the provider a written request for repayment that explains the basis for request. Within 90 days of receipt of the request, the provider shall either make appropriate repayment or respond with a specific written denial of the request.
6. If the provider and payor continue to disagree regarding the proper fee, either party may request informal review of the matter by the Division. Any party may also file a request for hearing on the dispute with the Adjudication Division.

R612-300-8. Travel Allowance For Injured Workers.

A. **Payment for travel to obtain medical care.** An injured worker who must travel outside his or her community to obtain necessary medical care is entitled to payment of meals, lodging and other travel expense. Payors shall reimburse injured workers for these expenses according to the standards set forth in State of Utah Accounting Policies and Procedures, Section FIACCT 10-02.00, "Travel Reimbursement," which standards are hereby incorporated by reference as part of these rules.
1. All travel must be by the most direct route and to the nearest location where adequate treatment is reasonably available.
2. Travel may not be required between the hours of 10:00 p.m. and 6:00 a.m., unless approved by the Commission.
B. **Time limits for requesting and paying travel expenses.**
1. Requests for travel reimbursement must be submitted to the payor for payment within one year after the subject travel expenses were incurred;
2. The payor must pay an injured employee's travel expenses at the earlier of:
   a. Every three months;
   b. Upon accrual of $100 in such expense; or
   c. At closure of the injured worker's claim.
C. Prescriptions. Travel allowance shall not include picking up prescriptions with the following exceptions:
1. Travel allowance will be allowed if documentation is provided substantiating a claim that prescriptions cannot be obtained locally within the injured worker's community;

2. Travel allowance will be allowed in instances where dispensing laws do not allow a medication to be called in to a pharmacy thus requiring an injured worker to physically obtain an original prescription from the provider's office.

R612-300-9. Permanent Impairment Ratings.

A. **Utah's 2006 Impairment Guides.** The "Utah 2006 Impairment Guides" are to be used to rate a permanent impairment not expressly listed in Section 34A-2-412 of the Utah Workers' Compensation Act.

B. **American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fifth Edition."** For those permanent impairments not addressed in either Section 34A-2-412 or the "Utah 2006 Impairment Guides," impairment ratings are to be established according to the American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fifth Edition."

R612-300-10. Medical Records.

A. **Relationship between HIPAA and workers' compensation disclosure requirements**. Workers' compensation insurers, employers and the Utah Labor Commission need access to health information of individuals who are injured on the job or who have a work-related illness in order to process or adjudicate claims, or to coordinate care under Utah's workers' compensation system. Generally, this health information is obtained from health care providers who treat these individuals and who may be covered by federal "HIPAA" privacy rules.
The HIPAA Privacy Rule specifically recognizes the legitimate need of the workers' compensation system to have access to individuals' health information to the extent authorized by State law. See 45 CFR 164.512(1). The Privacy Rule also recognizes the importance of permitting disclosures required by other laws. See 45 CFR 164.512(a). Therefore, disclosures permitted by this rule for workers' compensation purposes or otherwise required by this rule do not conflict with and are not prohibited by the HIPAA Privacy Rule.

B. **Disclosures permitted without authorization.** A medical provider, without authorization from the injured workers, shall:

1. For purposes of substantiating a bill submitted for payment or filing required Labor Commission forms, such as the "Physician's Initial Report of Injury/Illness" or the "Restorative Services Authorization," disclose medical records necessary to substantiate the billing, including drug and alcohol testing, to:
    a. An employer's workers' compensation insurance carrier or third party administrator;
    b. A self-insured employer who administers its own workers' compensation claims;
    c. The Uninsured Employers' Fund;
    d. The Employers' Reinsurance Fund; or
    e. The Labor Commission as required by Labor Commission rules.
2. Disclose medical records pertaining to treatment of an injured worker, who makes a claim for workers' compensation benefits, to another physician for specialized treatment, to a new treating physician chosen by the claimant, or for a consultation regarding the claimed work related injury or illness.

C. **Disclosures requiring authorization.**

1. Except as limited in C(3), a medical provider, whose medical records are relevant to a workers' compensation claim shall, upon receipt of a Labor Commission medical records release form, or an authorization form that conforms to HIPAA requirements, disclose his/her medical records to:

a. An employer's insurance carrier or third party administrator;

b. A self-insured employer who administers its own workers' compensation claims;

c. An agent of an entity listed in B (1) (a through e), which includes, but is not limited to a case manager or reviewing physician;

d. The Uninsured Employers Fund;

e. The Employers' Reinsurance Fund;

f. The Labor Commission;

g. The injured worker;

h. An injured workers' personal representative;

i. An attorney representing any of the entities listed above in an industrial injury or occupational disease claim.

2. Medical records are relevant to a workers' compensation claim if:

a. The records were created after the reported date of the accident or onset of the illness for which workers' compensation benefits have been claimed; or

b. The records were created in the past ten years (15 years if permanent total disability is claimed) and;

i. There is a specific reason to suspect that the medical condition existed prior to the reported date of the claimed work related injury or illness or

ii. The claim is being adjudicated by the Labor Commission.

3. Medical records related to care provided by a psychiatrist, psychologist, obstetrician, or care related to the reproductive organs may not be disclosed by a medical provider unless a claim has been made for a mental condition, a condition related to the reproductive organs, or the claimant has signed a separate, specific release for these records.

D. **Disclosure regarding return to work.** A medical provider, who has treated an injured worker for a work related injury or illness, shall disclose information to an injured workers' employer as to when and what restrictions an injured worker may return to work.

E. **Additional disclosures requiring specific approval.** Requests for medical records beyond what sections B, C, and D permit require a signed approval by the director, the medical director, a designated person(s) within the Industrial Accidents Division or an administrative law judge if the claim is being adjudicated.

F. **Appeals.** A party affected by the decision made by a person in section E may appeal that decision to the Adjudication Division of the Labor Commission.

G. **Injured worker's duty to disclose medical treatment and providers.** Upon receipt and within the scope of this rule, an injured worker shall provide those entities or person listed in C(1) the names, address, and dates of medical treatment (if known) of the medical providers who have provided medical care within the past 10 years (15 years for permanent total disability claim) except for those medical providers names in C(3). Labor Commission Form number 307 "Medical Treatment Provider List" must be used for this purpose. Parties listed in C(1) of this rule must provide each medical provider identified on form 307 with a signed authorization for access to medical records. A copy of the signed authorization may be sent to the medical providers listed on form 307.

H. **Injured worker's right to contest requests for pre-injury medical records.** An injured worker may contest, for good reason, a request for medical records created prior to the reported date of the accident or illness for which the injured worker has made a claim for benefits by filing a complaint with the Labor Commission. Good reason is defined as the request has gone beyond the scope of this rule or sensitive medical information is contained in a particular medical record.

I. **Limitations on use and re-disclosure of medical information.**

1. Any party obtaining medical records under authority of this rule may not disclose those medical records, without a valid authorization, except as required by law.
2. An employer may only use medical records obtained under the authority of this rule to:
   a. Pay or adjudicate workers' compensation claims if the employer is self-insured;
   b. To assess and facilitate an injured workers' return to work;
   c. As otherwise authorized by the injured worker.
3. An employer obtaining medical records under authority of this rule must maintain the medical records separately from the employee's personnel file.
4. Any medical records obtained under the authority of this rule to make a determination regarding the acceptance of liability or for treatment of a condition related to a workers' compensation claim shall only be used for workers' compensation purposes and shall not be released, without a signed release by the injured worker or his/her personal representative, to any other party. An employer shall make decisions related only to the workers' compensation claim based on any medical information received under this rule.

J. **Permissible fees for providing medical records.** When any medical provider provides copies of medical records, other than the records required when submitting a bill for payment or as required by the Labor commission rules, the following charges are presumed reasonable:
1. A search fee of $15 payable in advance of the search;
2. Copies at $.50 per page, including copies of microfilm, payable after the records have been prepared and
3. Actual costs of postage payable after the records have been prepared and sent. Actual cost of postage is deemed to be the cost of regular mail unless the requesting party has requested the delivery of the records by special mail or method.
4. The Labor Commission will release its records per the above charges to parties/entities with a signed and notarized release from the injured worker unless the information is classified and controlled under the Government Records Access and Management Act (GRAMA).
5. No fee shall be charged when the RBRVS or the Commission's Medical Fee Guidelines require specific documentation for a procedure or when medical providers are required to report by statute or rule.
6. An injured worker or his/her personal representative may obtain one copy of each of the following records related to the industrial injury or occupational disease claim, at no cost, when the injured worker or his/her personal representative have signed a form by the Industrial Accidents Division to substantiate his/her industrial injury/illness claim;
   a. History and physical;
   b. Operative reports of surgery;
   c. Hospital discharge summary;
   d. Emergency room records;
   e. Radiological reports;
   f. Specialized test results; and
   g. Physician SOAP notes, progress notes, or specialized reports.
   h. Alternatively, a summary of the patient’s records may be made available to the injured worker or his/her personal representative at the discretion of the physician.

R612-300-11. Utilization Review Standards.

A. **Purpose of utilization review and definitions.**
1. "Utilization Review" is used to manage medical costs, improve patient care and enhance decision-making. Utilization review includes, but is not limited to, the review of requests for authorization and the review of medical bills to determine whether the medical services were or

are necessary to treat a workplace injury. Utilization review does not include:

a. bill review for the purpose of determining whether the medical services rendered were accurately billed, or

b. any system, program, or activity used to determine whether an individual has sustained a workplace injury.

2. Any utilization review system shall incorporate a two-level review process that meets the criteria set forth in subsections B and C of this rule.

3. Definitions. As used in this rule:

a. "Request for Authorization" means any request by a physician for assurance that appropriate payment will be made for a course of proposed medical treatment.

b. "Reasonable Attempt" requires at least two phone calls and a fax, two phone calls and an e-mail, or three phone calls, within five business days from date of the payor's receipt of the physician's request for review.

B. **Level I--initial request and review.**

1. A health care provider may use Form 223 to request authorization and payment for proposed medical treatment. The provider shall attach all documentation necessary for the payor to make a decision regarding the proposed treatment.

a. Requests for approval of restorative services are governed by the provisions of Rule R612b-300.5. C. 7. which requires submission of the appropriate RSA form and documentation.

2. Upon receipt of the provider’s request for authorization, the payor may use medical or non-medical personnel to apply medically-based criteria to determine whether to approve the request. The payor must:

a. within 5 business days after receiving the request and documentation, transmit Form 223 back to the physician, in a verifiable manner, advising of the payor’s approval or denial of the proposed treatment.

i. If approval is denied, the payor must include with its denial a statement of the criteria it used to make its determination. A copy of the denial must also be mailed to the injured worker.

C. **Level II--review.**

1**.** A health care provider who has been denied authorization or has received no timely response may request a physician's review by completing and sending the applicable portion of Commission Form 223 to the payor.

a. The provider must include the times and days that he/she is available to discuss the case with the reviewing physician, and must be reasonably available during normal business hours.

b. This request for review may be used by a health care provider who has been denied authorization for restorative services pursuant to Rule R612-300-5. C. 7.

2. The payor's physician representative must complete the review within five business days of the treating physician's request for review. Additional time may be requested from the Commission to accommodate highly unusual circumstances or particularly difficult cases.

a. The insurer's physician representative must make a reasonable effort to contact the requesting provider to discuss the request for treatment. The payor shall notify the Commission if an additional five days is needed in order to contact the treating physician or to review the case.

b. If the payor again denies approval of the recommended treatment, the payor must complete the appropriate portion of Commission Form 223, and shall include:

i. the criteria used by the payor in making the decision to deny authorization; and

ii. the name and specialty of the payor's reviewing physician;

iii. appeals information.

c. The denial to authorize payment for treatment must then be sent to the physician, the injured worker and the Commission.

3. The payor's failure to respond to the review request within five business days, by a method which provides certification of transmission, shall constitute authorization for payment of the treatment.

D. **Mediation and adjudication.** Upon receipt of denial of authorization for payment for medical treatment at Level II, the Commission will facilitate, upon the request of the injured worker, the final disposition of the case.

1. If the parties agree, the medical dispute will be referred to Commission staff for mediation.

2. If the parties do not agree to mediation, the matter will be referred to the Division of Adjudication for hearing and decision.

E. **Reduction of fee for failure to follow utilization review standards.**

1. In cases in which a health care provider has received notice of this rule but proceeds with non-emergency medical treatment without obtaining payor authorization, the following shall apply:

a. If the medical treatment is ultimately determined to be necessary to treat a workplace injury, the fee otherwise due the health care provider shall be reduced by 25%.

b. If the medical treatment is ultimately determined to be unnecessary to treat a workplace injury, the payor is not liable for payment for such treatment. The injured worker may be liable for the cost of treatment.

2. The penalty provision in D. 1. shall not apply if the medical treatment in question has been preauthorized by some other non-worker's compensation insurance company or other payor.

R612-300-12. Commission Approval of Health Care Treatment Protocols.

A. **Authority.** Pursuant to authority granted by Section 34A-2-111(2)(c)(i)(B)(VII) of the Utah Workers' Compensation Act, the Utah Labor Commission establishes the following standards and procedures for Commission approval of medical treatment and quality care guidelines.

B. **Standards:**

1. Scientifically based: Section 34A-2-111(2)(c)(i)(B)(VII)(Aa) of the Act requires that guidelines be scientifically based. The Commission will consider a guideline to be "scientifically based" when it is supported by medical studies and/or research.

2. Peer reviewed: Section 34A-2-111(2)(c)(i)(B)(VII)(Bb) of the Act requires that guidelines be peer reviewed. The Commission will consider a guideline to be "peer reviewed" when the medical study's content, methodology, and results have been reviewed and approved prior to publication by an editorial board of qualified experts".

3. Other standards: Pursuant to its rulemaking authority under Section 34A-2-111(2)(c)(i)(B)(VII), the Utah Labor Commission establishes the following additional standards for medical treatment and quality care guidelines.

a. The guidelines must be periodically updated and, subject to Commission discretion, may not be approved for use unless updated in whole or in part at least biannually;

b. Guideline sources must be identified;

c. The guidelines must be reasonably priced;

d. The guidelines must be easily accessible in print and electronic versions.

C. **Procedure:** Pursuant to Section 34A-2-111(2)(c)(i)(B)(VII) of the Utah Workers' Compensation Act, a party seeking Commission action to approve or disapprove a guideline shall file a petition for such action with the Labor Commission.

R612-300-13. HIV, Hepatitis B and C Testing and Reporting for Emergency Medical Service Providers.

A. **Purpose and authority.** This rule, established pursuant to U.C.A. Section 78B-8-404, establishes procedures for testing and reporting following a significant exposure of an emergency medical services provider to infectious diseases.

B. **Definitions.** In addition to the terms defined in Section 78B-8-401, the following definitions apply for purposes of this rule.

1. Contact means designated person(s) within the emergency medical services agency or the employer of the emergency medical services provider.

2. Emergency medical services (EMS) agency means an agency, entity, or organization that employs or utilizes emergency medical services providers as defined in (4) as employees or volunteers.

3. Source Patient means any individual cared for by a prehospital emergency medical services provider, including but not limited to victims of accidents or injury, deceased persons, and prisoners or persons in the custody of the Department of Corrections, a county correctional facility, or a public law enforcement entity.

4. Receiving facility means a hospital, health care or other facility where the patient is delivered by the emergency medical services provider for care.

C. **Emergency medical services provider responsibility.**

1. The EMS provider shall document and report all significant exposures to the receiving facility and contact as defined in (C)(2).

2. The reporting process is as follows:

a. The exposed EMS provider shall complete the Exposure Report Form (ERF) at the time the patient is delivered to the receiving facility and provide a copy to the person at the receiving facility authorized by the facility to receive the form. In the event the exposed EMS provider does not accompany the source patient to the receiving facility, he/she may report the exposure incident, with information requested on the ERF, by telephone to a person authorized by the facility to receive the form. In this event, the exposed EMS provider shall nevertheless submit a written copy of the ERF within three days to an authorized person of the receiving facility.

b. The exposed EMS provider shall, within three days of the incident, submit a copy of the ERF to the contact as defined in (C)(2).

D. **Receiving facility responsibility.**

1. The receiving facility shall establish a system to receive ERFs as well as telephoned reports from exposed EMS providers on a 24-hour per day basis. The facility shall also have available or on call, trained pre-test counselors for the purpose of obtaining consent and counseling of source patients when HIV testing has been requested by EMS providers. The receiving facility shall contact the source patient prior to release from the facility to provide the individual with counseling or, if unable to provide counseling, provide the source patient with phone numbers for a trained counselor to provide the counseling within 24 hours.

2. Upon notification of exposure, the receiving facility shall request permission from the source patient to draw a blood sample for disease testing. In conjunction with this request, the source patient must be advised of his/her right to refuse testing and be advised that if he/she refuses to be tested that fact will be forwarded to the EMS agency or employer of EMS provider. The source patient shall also be advised that if he/she refuses to be tested, the EMS agency or

provider may seek a court order to compel the source patient to submit to a blood draw for the disease testing. Testing is authorized only when the source patient, his/her next of kin or legal guardian consents to testing, with the exception that consent is not required from an individual who has been convicted of a crime and is in the custody or under the jurisdiction of the Department of Corrections, a county correctional facility, a public law enforcement entity, or if the source patient is dead. If consent is denied, the receiving facility shall complete the ERF and send it to the EMS agency or employer of the EMS provider. If consent is received, the receiving facility shall draw a sample of the source patient's blood and
send it, along with the ERF, to a qualified laboratory for testing.

3. The laboratory that the receiving facility has sent source patient's blood draw to shall send the disease test results, by Case ID number, to the EMS agency or employer of the EMS provider.

E. **EMS agency/employer responsibility:**

1. The EMS agency/employer, upon receipt of the disease tests, from the receiving facility laboratory, shall immediately report the result, by case number, not name, to the exposed EMS provider.
2. The EMS agency/employer, upon the receipt of refusal of testing by the source, shall report that refusal to the EMS provider.
3. The agency/employer or its insurance carrier shall pay for the EMS provider and the source patient testing for the covered diseases per the Labor Commission fee schedule.
4. The EMS agency/employer shall maintain the records of any disease exposures contained in this rule per the OSHA Blood Borne Pathogen standards.